



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ANESTHESIA ALLIANCE OF DALLAS
PO BOX 202918
DALLAS, TX 75320-2918

Carrier's Austin Representative Box

19

Respondent Name

Dallas ISD

MFDR Date Received

May 8, 2012

MFDR Tracking Number

M4-12-2860-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Code 99195 59 was denied stating "benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated...The carrier is responsible for payment of this unpaid code..."

Amount in Dispute: \$110.27

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Since the submitted medical records did not indicate that the CRNA was involved with drawing 60ml of blood from the claimant, no allowance was recommended..."

Response Submitted by: Argus Services Corporation, 9101 LBJ Freeway, Suite 600, Dallas, TX 75243-2055

SUMMARY OF FINDINGS

Disputed Dates	Disputed Services	Amount In Dispute	Amount Due
February 12, 2012	99195-59	\$110.27	\$110.27

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. Former 28 Texas Administrative Code, §133.305 and §133.307, 33 *Texas Register* 3954, applicable to requests filed on or after May 25, 2008, sets out the procedures for resolving medical fee disputes filed prior to June 1, 2012
2. 28 Texas Administrative Code §133.20 sets out medical bill submission requirements for health care providers
3. 28 Texas Administrative Code §134.203 sets out guidelines for professional medical services
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
Explanation of Benefits dated March 30, 2012
 - W1A-Workers Compensation State Fee Schedule Adjustment "Reimbursement per Rule 134.203/134.204. Prior to March 1, 2008, Rule 134.202."

- 97H-The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. "Service(s)/Procedure is included in the value of another service/procedure billed on the same date."

Explanation of Benefits dated April 26, 2012

- 193W-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly. "Previous recommendation was in accordance with the Worker's Compensation State Fee Schedule."
- 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 97H-The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. "Service(s) Procedure is included in the value of another service/procedure billed on the same date."

Issues

1. Did the respondent raise a new denial reason?
2. Is the service in dispute included in the value of another service/procedure?
3. Is the requestor entitled to additional reimbursement?

Findings

1. In its response to medical fee dispute resolution, the respondent states that "The use of modifier 59 requires documentation to support the procedure was distinct or independent from the other codes performed on the same day." Applicable 28 Texas Administrative Code §133.307 (d)(2)(B) states "The response shall address only those denial reasons presented to the requestor prior to the date the request for MDR was filed with the Division and the other party. Any new denial reasons or defenses raised shall not be considered in the review." No documentation was found to support that the respondent presented this denial reason prior to the request for MFDR. The division concludes that the carrier raised a new denial reason. For that reason, the carrier's position regarding the 59 modifier shall not be considered in this review.
2. The service in dispute was denied, in part, due to "Service(s) Procedure is included in the value of another service/procedure billed on the same date." 28 Texas Administrative Code §134.203(b)(1) states, in pertinent part, "for coding, billing, reporting and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits..." Medicare's CCI edits may be found at <http://www.cms.gov>. Review of the CCI public files, along with the medical bill provided by the parties finds that 99195 does not conflict with the other service billed. The division notes that regardless of whether or not the -59 modifier is appended, no conflict exists in CCI. The division finds that the service in dispute is not included in another service billed on the same day, therefore reimbursement is recommended.
3. The total reimbursement for 99195-59 may be determined using division rule 28 TAC §134.203 (c)(1) which states "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications...(1) For service categories of Evaluation & Management, General Medicine..." The service in dispute is found in the general medicine section of the AMA CPT code book; therefore the maximum allowable reimbursement (MAR) = (TDI-DWC Medicine Conversion Factor / Medicare conversion factor) x Medicare Price or $(\$54.86 / 34.0376) \times \$94.54 = \$152.37$. The amount in dispute is \$110.27, this amount is recommended for payment.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$110.27.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$110.27 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

February 5, 2013
Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.**

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.